anovo
SPECIALTY PHARMACY

Fax: 855-813-2039
Phone: 888-487-4703

CYSTADANE®
(betaine anhydrous for oral solution) powder
Prescription Order Form

Please select one: ☐ **Newly Prescribed Patient** ☐ **Patient Currently on Cystadane®**

Patient Information **Please print*

Last Name: First Name:		SSN:	Sex: ◯M ◯F
Address:	City:	State:	Zip:
Phone: Day #	Evening #:	Cell # :	
DOB:	Ht: ft. in. Wt: lbs.	Date Weight Taken:	
If Patient is a Minor, Guardian/Parent Name:		Relation to Patient:	
Emergency Contact:		Phone #:	

Insurance Information **Include copies of insurance cards*

Primary Insurance Co. Name:		Phone #:
Policy Holder Name:	Policy #:	Group #:
Prescription Card Name:		Phone #:
Policy #:		Group #:
Secondary Insurance Co. Name:		Phone #:
Policy Holder Name:	Policy #:	Group #:

Physician Information

Prescriber Name/Title:			
NPI:	DEA:	Medicaid UPIN:	State License #:
Address:			
City:	State:	Zip:	
Name of Contact Person:			Phone:
Physician Email:			Fax:

Prescription

CYSTADANE® (betaine anhydrous for oral solution) powder 1 bottle = 180 grams

Sig: Dissolve _____ scoop(s) in 4–6 ounces (120-180ml) of water, juice, milk, or formula, or mixed with food for immediate ingestion. (Note: 1 scoop = 1 gram)

Solution should be taken _____ time(s) daily. Quantity to dispense _____ bottles.

Refills _____

PLEASE NOTE: Because Cystadane is only supplied in bottles containing 180 grams, the actual day's supply provided by one bottle of Cystadane will vary depending on the patient's daily dose. Cystadane is not available in amounts smaller than 180 grams per bottle.

Medical Necess

Primary diagnosis:	Date of Diagnosis :	Patient Age at Diagnosis:

Please check applicable ICD-10 code:

☐ Homocystinuria (E72.11) ☐ Methylmalonic Acidemia with Homocystinuria (E71.120) ☐ MTHFR Deficiency (E72.12)
☐ Methylcobalamin deficiency (E53.8) ☐ Other (please specify)

Therapy Start Date:

Allergies ☐ NKDA

I certify I am prescribing CYSTADANE® for this patient for a medically necessary purpose. **Date Written:** _____

Dispense as Written: _____
(Stamped Signatures Are Not Valid)

Substitution Allowed: _____
(Stamped Signatures Are Not Valid)

This Prescription Form is only valid if FAXED to Anovo @ 855-813-2039

Form: CYS.RX.01
Effective Date: 07/01/2014
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